Medicare B CONNECTION

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

June 2020

In this issue

Special message to First Coast's Medicare providers in Puerto Rico

Since 2009, First Coast has proudly served as your Medicare administrative contractor for jurisdiction N, which includes Puerto Rico, Florida, and the U.S. Virgin Islands. On our behalf, Triple-S Salud has performed a few services to providers of the original Medicare program in Puerto Rico. These services include customer service (telephone and written inquiries), first-level appeal requests, and provider education.

Recently, we shared that Triple-S Salud will no longer provide these support services for our providers in Puerto Rico as of July 1, 2020. These services will be delivered directly by us, First Coast.

Same exceptional customer service in your preferred language

As you've come to expect from First Coast, same exceptional customer service will be provided in your preferred language of Spanish or English. We're working closely with our partners at Triple-S Salud to ensure a seamless transition for you:

- **Customer service and IVR:** Our customer service and interactive voice response (IVR) telephone numbers will remain the same. As always, you can access this information from our *Contact Center* webpage.
- **Provider outreach and education:** We'll continue keeping you informed on the latest in the Medicare program with face-to-face events, webinars, and outreach activities in Spanish and English with experienced representatives.
- **Appeals:** We'll continue responding to your first level-appeal requests in the language you communicate to us.

Contact us for additional assistance

Our commitment to you is excellent customer service. If you have additional questions, please contact First Coast's Cesar Hernandez at *Cesar.Hernandez@fcso.com*, or Executive Contractor Medical Director Dr. Juan Schaening *at Juan.Schaening-Perez@fcso.com*.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Contents

The *Medicare B Connection* is published monthly by First Coast Service Options Inc.'s Provider Outreach & Education division to provide timely and useful information to Medicare Part B providers.

Articles included in the *Medicare B Connection* represent formal notice of coverage policies. Policies have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined within to ensure compliance with Medicare coverage and payment guidelines.

About the Medicare B Connection

The *Medicare B Connection* is a comprehensive publication developed by First Coast Service Options Inc. (First Coast) for Part B providers in Florida, Puerto Rico, and the U.S. Virgin Islands and is distributed on a monthly basis.

Important notifications that require communication in between publications will be posted to the First Coast Medicare *provider education website*. In some cases, additional unscheduled special issues may be posted.

Who receives the *Connection*

Anyone may view, print, or download the *Connection* from our provider education website(s). Providers who cannot obtain the *Connection* from the internet are required to register with us to receive a complimentary hardcopy.

Distribution of the *Connection* in hardcopy is limited to providers who have billed at least one Part B claim to First Coast Medicare during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, if a technical barrier exists that prevents them from obtaining it from the internet and they have returned a completed registration form to us.

Registration forms must be submitted annually or when you experience a change in circumstances that impacts your electronic access.

For additional copies, providers may purchase a separate annual subscription (see order form in the back of this issue). All issues published since 1997 may be downloaded from the internet, free of charge.

We use the same mailing address for all correspondence, and cannot designate that the *Connection* be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare provider enrollment department. Please remember that address changes must be done using the appropriate CMS-855.

Publication format

The *Connection* is arranged into distinct sections.

- The **Claims** section provides claim submission requirements and tips.
- The **Coverage/Reimbursement** section discusses specific CPT® and HCPCS procedure codes. It is arranged by categories (not specialties). For example, "Mental Health" would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.

- The section pertaining to **Electronic Data Interchange** (EDI) submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA).
- The **Local Coverage Determination** section features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives.
- The **General Information** section includes fraud and abuse, and national provider identifier topics, plus additional topics not included elsewhere.
- In addition to the above, other sections include:
- **Educational Resources**, and
- **Contact information** for Florida, Puerto Rico, and the U.S. Virgin Islands.

The *Medicare B Connection* represents formal notice of coverage policies

Articles included in each edition represent formal notice that specific coverage policies either have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines.

Never miss an appeals deadline again

When it comes to submitting a claims appeal request, *timing is everything*. Don't worry – you won't need a desk calendar to count the days to your submission deadline. Try our *"time limit" calculators on our Appeals of claim decisions page*. Each calculator will *automatically calculate* when you must submit your request based upon the date of either the initial claim determination or the preceding appeal level.

Medicare Part B advance beneficiary notices

Medicare Part B allows coverage for services and items deemed medically reasonable and necessary for treatment and diagnosis of the patient.

For some services, to ensure that payment is made only for medically necessary services or items, coverage may be limited based on one or more of the following factors (this list is not inclusive):

- Coverage for a service or item may be allowed only for specific diagnoses/conditions. Always code to the highest level of specificity.
- Coverage for a service or item may be allowed only when documentation supports the medical need for the service or item.
- Coverage for a service or item may be allowed only when its frequency is within the accepted standards of medical practice (i.e., a specified number of services in a specified timeframe for which the service may be covered).

If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment if the provider does not want to accept financial responsibility for the service or item. Advance beneficiary notices (ABNs) advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment.

Patient liability notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the Advance Beneficiary Notice of Noncoverage (ABN) (Form CMS-R-131), formerly the "Advance Beneficiary Notice." Section 50 of the *Medicare Claims Processing Manual* provides instructions regarding the notice that these providers issue to beneficiaries in advance of initiating, reducing, or terminating what they believe to be noncovered items or services. The ABN must meet all of the standards found in Chapter 30. Beginning March 1, 2009, the ABN-G and ABN-L was no longer valid; and notifiers must use the revised Advance Beneficiary Notice of Noncoverage (CMS-R-131). *Section 50 of the Medicare Claims Processing Manual*.

Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found *here*.

ABN modifiers

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting modifier GA (waiver of liability statement on file) or GZ (item or service expected to be denied as not reasonable and necessary) with the service or item.

Failure to report modifier GA in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Modifier GZ may be used in cases where a signed ABN is not obtained from the patient; however, when modifier GZ is billed, the provider assumes financial responsibility if the service or item is denied.

Note: Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.

GA modifier and appeals

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting the modifier GA (waiver of liability statement on file).

Failure to report modifier GA in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Nonassigned claims containing the modifier GA in which the patient has been found liable must have the patient's written consent for an appeal. Refer to the applicable contact section located at the end of this publication for the address in which to send written appeals requests.

COBA

COBA trading partners' non-payment of NGACO claims containing CARC 132

On February 7, 2017, and July 15, 2018, the Centers for Medicare & Medicaid Services (CMS) issued notifications to all Coordination of Benefits Agreement (COBA) trading partners concerning the Next Generation Accountable Care Organization (NGACO) Model demonstration project (including information regarding the All-Inclusive Population-Based Payment (AIPBP) aspect of the project). These notices emphasized the significance of Claim Adjustment Reason Code (CARC) 132, including what its presence signified.

CMS is re-alerting all COBA trading partners to critical information about the NGACO Model demonstration project, which has been activated within the traditional Medicare program.

Background

The aim of the NGACO Model is to improve the quality of care, population health outcomes, and patient experience for the beneficiaries who choose traditional Medicare fee-for-service (FFS) through greater alignment of financial incentives and greater access to tools that may aid beneficiaries and providers in achieving better health at lower costs.

The purpose of the NGACO Model (also known as the "Next Generation Model," "Next Generation," or the "Model") is to test whether strong financial incentives for ACOs can improve health outcomes and reduce expenditures for Medicare FFS beneficiaries. The Model offers financial arrangements with higher levels of risk and reward than current Medicare ACO initiatives, using refined benchmarking methods that: (1) reward quality performance; (2) reward both attainment of and improvement in cost containment; and (3) ultimately transition away from reference to ACO historical expenditures. The Model additionally offers a selection of alternative payment mechanisms to enable a graduation from FFS reimbursements to capitation.

Key information for COBA trading partners

- NGACO applies to both 837 institutional and professional claims.
- NGACO 837 crossover claims will include demonstration project code 74, reported in REF02 of 2300 REF (Demonstration Project Identifier), where REF01=P4.
- Increasingly, Medicare NGACO claims may be paid through an alternative payment mechanism with the Next Generation ACOs called All-Inclusive Population-Based Payment (AIPBP). In such cases, the claims will feature CARC 132 on them.

Extremely important -- please read carefully

- COBA trading partners can tell an NGACO is participating in AIPBP by the presence of a Medicare payment amount of $0 and an amount qualified by Group Code "CO (Contractual Obligation)" and CARC "132." Important: The $0.00 paid amount does not mean that Medicare denied the claim.
- The presence of CO-132 means the NGACO, rather than Medicare, is directly paying the provider of service. Therefore, Medicare's payment amount is reflected as $0. By no means should COBA trading partners deny claims with CARC 132, proceeding under the assumption that Medicare itself denied the claims

Trading partner actions requested

- CMS requests COBA trading partners which may not have paid NGACO (Demo 74) claims because they contained CARC 132 and an associated amount of $0.00 to reprocess the affected claims.
- This notice is of highly critical importance. We ask our COBA trading partners take any necessary systems actions to ensure they will no longer regard NGACO claims containing CARC 132 (CO-132) and an associated amount of $0.00 as "not paid by Medicare."

Questions?

The Benefits Coordination & Recovery Center (BCRC) houses the COBA trading partner's information for crossover purposes. Direct questions regarding this notification to the BCRC's Electronic Data Interchange (EDI) Department.

EDI Department

BCRC/Medicare

cobva@ghimedicare.com

P# 646-458-6740

F# 646-458-6761.

Background

Section 1135 and Section 1812(f) Waivers

Source: BCRC COBA EDI Department

This section of *Medicare B Connection* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the Medicare administrative contractor (MAC) jurisdiction N (JN) Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

Refer to our *LCDs/Medical Coverage webpage* for full-text LCDs, including final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries.

Effective and notice dates

Effective dates are provided in each LCD, and are based on the date services are furnished unless otherwise noted in the LCD. Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the website is considered the notice date.

Electronic notification

To receive quick, automatic notification when new and revised LCDs are posted to the website, subscribe to the *First Coast eNews mailing list*. Simply enter your email address and select the subscription option that best meets your needs.

More information

For more information, or, if you do not have internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

Medical Policy and Procedures
PO Box 2078
Jacksonville, FL 32231-0048

Looking for LCDs?

Would you like to find local coverage determinations (LCD) in 10 seconds or less? *First Coast's LCD lookup* helps you find the coverage information you need quickly and easily. Just enter a procedure code, keyword, or the LCD's "L number," click the corresponding button, and the application will automatically display links to any LCDs applicable to the parameters you specified. Best of all, depending upon the speed of your internet connection, the LCD search process can be completed in less than 10 seconds.

Advance beneficiary notice

Modifier GZ must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.

Note: Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.

Modifier GA must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.

All claims not meeting medical necessity of a local coverage determination must append the billed service with modifier GA or GZ.

Your Feedback Matters

To ensure that our website meets the needs of our provider community, we carefully analyze your feedback and implement changes to better meet your needs. Discover the results of your feedback on our "*Website enhancements*" page. You'll find the latest enhancements to our provider websites and find out how you can share your thoughts and ideas with First Coast's web team.

New LCDs/Articles

Screening for cervical cancer for human papillomavirus (HPV) screening - New Part A and Part B billing and coding article

Article ID number: A58232 (Florida, Puerto Rico/U.S. Virgin Islands)

It has come to the attention of First Coast Service Options, Inc. that services submitted for screening for cervical cancer with Human Papillomavirus (HPV) Testing have been reported incorrectly.

Therefore, a billing and coding article (A58232) has been developed to provide guidance for these services.

This new billing and coding article is consistent with National Coverage Determination (NCD) 210.2.1.

Effective date

This new billing and coding article is effective for services rendered **on or after June 4, 2020**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Revised LCDs/Articles

Allergy testing – revision to Part A and Part B LCD/billing and coding article

LCD and Article ID numbers: L33261/A57531 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on a Centers for Medicare & Medicaid Services (CMS) directive, the local coverage determination (LCD) for allergy testing was revised to remove language in the "Limitations" section. In addition, Current Procedural Terminology (CPT®) code 86001 was removed from the "CPT®/HCPCS Codes/Group 5 Codes:" and "ICD-10 codes that DO NOT Support Medical Necessity/Group 1 Paragraph:" sections of the billing and coding article. Also, the "CPT®/HCPCS Codes/Group 5 Paragraph:" section of the billing and coding article was updated to revise the language related to CPT® code 86005 to indicate it is not covered per the Medicare screening benefit.

Effective date

This LCD and billing and coding article revision is effective for services rendered **on or after July 01, 2020**.

LCDs are available through the CMS Medicare coverage database at

https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

CYP2C19, CYP2D6, CYP2C9, and VKORC1 genetic testing - revision to the Part A and Part B LCD/billing and coding article

LCD and Article ID numbers: L35698/A57704 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on a Centers for Medicare & Medicaid Services (CMS) directive, the "Coverage Indications, Limitations, and/or Medical Necessity" section of the local coverage determination (LCD) for CYP2C19, CYP2D6, CYP2C9, and VKORC1 genetic testing is being revised to remove language regarding CYP2C9 and VKORC1 genetic testing.

In addition, the "CPT®/HCPCS Codes/Group 3 Paragraph:/Codes:" section of the billing and coding article is being removed.

Effective date

This LCD and billing and coding article revision is effective for services rendered **on or after July 01, 2020**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Psychological and neuropsychological tests - revision to the Part A and Part B LCD

LCD ID number: L34520 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a Centers for Medicare & Medicaid Services (CMS) directive, the local coverage determination (LCD) for psychological and neuropsychological tests was revised to remove language in the "Limitations" section regarding Alzheimer's disease.

Effective date

This LCD revision is effective for services rendered **on or after July 01, 2020**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Psychiatric diagnostic evaluation and psychotherapy services - revision to the Part A and Part B LCD

LCD ID number: L33252 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a Centers for Medicare & Medicaid Services (CMS) directive, the local coverage determination (LCD) for psychiatric diagnostic evaluation and psychotherapy services was revised to remove language in the "Limitations" section regarding multiple family group psychotherapy.

Effective date

This LCD revision is effective for services rendered **on or after July 01, 2020**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Magnetic Resonance Angiography (MRA) – revision to Part A and Part B LCD/billing and coding article

LCD and Article ID numbers: L34372/A57779 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on a Centers for Medicare & Medicaid Services (CMS) directive, the local coverage determination (LCD) for magnetic resonance angiography (MRA) was revised to remove language in the "Limitations" section. In addition, the "CPT®/HCPCS Codes/Group 3 Paragraph:/Group 3 Codes:/HCPCS codes C8931-C8936" and "CPT®/HCPCS Codes/Group 4 Paragraph:/Group 4 Codes:/CPT®/HCPCS codes 72159, 73225, C8931-C8936" sections of the billing and coding article have been removed.

Effective date

This LCD and billing and coding article revision is effective for services rendered **on or after July 01, 2020**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Epidural - revision to the Part B billing and coding article

Article ID number: A56651 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on review of the local coverage determination for epidural, a decision was made to remove Current Procedural Terminology (CPT®) codes 62321 and 62323 from the "ICD-10 Codes that Support Medical Necessity/ Group 1 Paragraph" section of this billing and coding article. In addition, the "CPT®/HCPCS Codes/Group 1 Paragraph" section of this billing and coding article was revised to add the following language: "The following CPT® codes will not have diagnosis to procedure code limitations applied at this time: 62320, 62321, 62322, and 62323."

Effective date

This billing and coding article revision is effective for claims processed **on or after June 4, 2020**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Polysomnography and sleep testing– revision to the Part A and Part B LCD/billing and coding article

LCD and Article ID numbers: L33405/A57496 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on a Centers for Medicare & Medicaid Services (CMS) directive, the "Limitations" section of the local coverage determination (LCD) for polysomnography and sleep testing was revised to remove language regarding actigraphy.

In addition, the "CPT®/HCPCS Codes/Group 5 Paragraph:/Group 5 Codes:/CPT® code 95803" sections of the billing and coding article have been removed.

Effective date

This LCD and billing and coding article revision is effective for services rendered **on or after July 01, 2020**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Pulmonary diagnostic services – revision to Part A and Part B LCD/billing and coding article

LCD and Article ID numbers: L33707/A57127 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on a Centers for Medicare & Medicaid Services (CMS) directive, the "Limitations" section of the local coverage determination (LCD) and the "Coding Guidelines" section of the billing and coding article for pulmonary diagnostic services were revised to remove language regarding patient initiated spirometry.

Effective date

This LCD and billing and coding article revision is effective for services rendered **on or after July 01, 2020**.

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Treatment of varicose veins of the lower extremity – revision to Part A and Part B billing and coding article

Article ID numbers: A57781 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on a Centers for Medicare & Medicaid Services (CMS) directive, the "CPT®/HCPCS Codes/Group 2 Paragraph:/Group 2 Codes:/CPT® codes 36465, 36466, 36473, and 36474" and "ICD-10 Codes that DO NOT Support Medical Necessity /Group 1 Paragraph:/Group 1 Codes:/ CPT® code 37241" sections of the billing and coding article for treatment of varicose veins of the lower extremity have been removed.

Effective date

This LCD and billing and coding article revision is effective for services rendered **on or after July 01, 2020**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Retired LCDs/Articles

Respiratory therapeutic services – retired Part A and Part B LCD/billing and coding article

LCD and Article ID numbers: L33745/A57128 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on data analysis and review of the local coverage determination (LCD) for respiratory therapeutic services, it was determined that the LCD is no longer required. Therefore, the LCD and its related billing and coding article are being retired.

Effective date

The retirement of this LCD and billing and coding article is effective for services rendered **on or after July 01, 2020**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Diagnostic evaluation and medical management of moderate-severe dry eye disease (DED) - retired Part A and Part B LCD/billing and coding article

LCD and Article ID numbers: L36232/A57676 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on review of the local coverage determination (LCD) and billing and coding article for diagnostic evaluation and medical management of moderate-severe dry eye disease (DED), it was determined that they are no longer required and therefore, are being retired.

Effective date

This LCD and billing and coding article retirement is effective for services rendered **on or after June 25, 2020**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Noncovered services - retired Part A and Part B LCD/billing and coding article

LCD and Article ID numbers: L33777/A57743 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on a Centers for Medicare & Medicaid Services (CMS) directive, the local coverage determination (LCD) and billing and coding article for noncovered services are being retired.

Effective date

The retirement of this LCD and billing and coding article is effective for services rendered **on or after July 01, 2020**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Dysphagia/swallowing diagnosis and therapy - retired Part A and Part B LCD/billing and coding article

LCD and Article ID numbers: L34043/A57675 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on Centers for Medicare & Medicaid Services (CMS) directive, the local coverage determination (LCD) and billing and coding article for dysphagia/swallowing diagnosis and therapy are being retired.

Effective date

The retirement of this LCD and billing and coding article is effective for services rendered **on or after July 01, 2020**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Upcoming provider outreach and educational events

COVID-19 advance Medicare payments recoupment process (A/B)

Date: July 23
Time: 10 - 11:00 a.m. ET
Type of Event: Webcast

View our complete calendar of events

Note: Unless otherwise indicated, designated times for educational events are stated as ET, and the focus is to Florida, Puerto Rico, and the U.S. Virgin Islands.

Two easy ways to register

Online – Visit our provider training website at *First Coast University*, log on to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**.**

First-time User? Set up an account by completing *Create User Account Form* online. Providers who do not have yet a national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.

Fax – Providers without internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. Class materials will be faxed to you the day of the event.

Please Note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to opening of event registration.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking our *website* for details and newly scheduled educational events (teleconferences, webcasts, etc.).

Never miss a training opportunity

If you or your colleagues were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit the First Coast Medicare training website, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

In addition to live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. In addition, our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Learn more on the First Coast Medicare training website and explore our catalog of online courses.

CMS MLN Connects®

The Centers for Medicare & Medicaid Services (CMS) *MLN Connects*® is an official *Medicare Learning Network*® (*MLN*) – branded product that contains a week's worth of news for Medicare fee-for-service (FFS) providers. CMS sends these messages weekly to national health industry provider associations, who then disseminates the *MLN Connects*® to its membership as appropriate.

MLN Connects - Special Edition – Tuesday, May 19, 2020

COVID-19: Payment for Lab Tests, Safely Reopening Nursing Homes, Lab & Ambulance Claims

- *COVID-19: Payment for Diagnostic Laboratory Tests*
- *Trump Administration Issues Guidance to Ensure States Have a Plan in Place to Safely Reopen Nursing Homes*
- *COVID-19: Which Laboratory Claims Require the NPI of the Ordering/Referring Professional?*
- *COVID-19: Ambulance Claims for Alternative Sites*

COVID-19: Payment for Diagnostic Laboratory Tests

Earlier this year, CMS took action to ensure America's patients, health care facilities, and clinical laboratories were prepared to respond to the 2019-Novel Coronavirus (COVID-19). To help increase testing and track new cases, CMS developed two HCPCS codes that laboratories can use to bill for certain COVID-19 diagnostic tests. Health care providers and laboratories may bill Medicare and other health insurers for SARS-CoV2 tests performed on or after February 4 using:

- HCPCS code U0001 for tests developed by the Centers for Disease Control and Prevention (CDC)
- HCPCS code U0002 for non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19)

Laboratories and other health providers can also bill Medicare for tests using CPT codes created by the American Medical Association, provided testing uses the method specified by each CPT code:

- CPT code 87635 for infectious agent detection by nucleic acid tests for dates of service on or after March 13
- CPT codes 86769 and 86328 for serology tests for dates of service on or after April 10

Finally, for dates of service on or after April 14, 2020, *Medicare pays $100 for laboratory tests for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19 making use of high throughput technologies.* Laboratories can bill Medicare for these tests using:

- U0003: Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R.
- U0004: 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R

Neither U0003 nor U0004 should be used to bill for tests that detect COVID-19 antibodies.

For COVID-19 tests that do not use high throughput technology, Medicare Administrative Contractors developed *payment amounts* for claims in their jurisdictions that will be used until we establish national payment rates though the annual laboratory meeting process. There is no cost-sharing for Medicare patients.

Trump Administration Issues Guidance to Ensure States Have a Plan in Place to Safely Reopen Nursing Homes

On May 18, under the leadership of President Trump, CMS announced new guidance for state and local officials to ensure the safe reopening of nursing homes across the country. The guidance released is part of President Trump's Guidelines for Opening Up America Again. The recommendations issued would allow states to make sure nursing homes are continuing to take the appropriate and necessary steps to ensure resident safety and are opening their doors when the time is right. This also serves to help states and nursing homes reunite families with their loved ones in a safe, phased manner.

Press Release

COVID-19: Which Laboratory Claims Require the NPI of the Ordering/Referring Professional?

During the COVID-19 Public Health Emergency, CMS is relaxing billing requirements for a *limited number of laboratory tests* required for a COVID-19 diagnosis. Any health care professional authorized under state law may order these tests. Medicare will pay for these tests without a written order from the treating physician or other practitioner:

- If an order is not written, you do not need to provide the National Provider Identifier (NPI) of the ordering or referring professional on the claim

See **MLN**, page 13

MLN

from page 12

- If an order is written, include the NPI of the ordering or referring professional, consistent with current billing guidelines

For More Information:

Laboratory Tests with modified requirements.

Interim Final Rule

COVID-19: Ambulance Claims for Alternative Sites

During the COVID-19 Public Health Emergency, Medicare covers medically necessary emergency and non-emergency ground ambulance transportation from any point of origin to a destination that is equipped to treat the condition of the patient consistent with state and local Emergency Medical Services (EMS) protocols where the services will be furnished.

Medicare Administrative Contractors are now processing claims according to the details provided in the *April 7 message*. If you believe that your previously processed claims were denied in error, contact your *Medicare Administrative Contractor* to have these claims reprocessed.

MLN Connects® for Thursday, May 21, 2020

MLN Connects® for Thursday, May 21, 2020

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News

- CMS Releases Additional Waivers for Hospitals and Ground Ambulance Organizations
- Hospice Quality Reporting Program: Quarterly Update for January - March
- Nursing Home Quality Initiative: Updated MDS 3.0 Item Sets
- Hospitals: Submit Medicare GME Affiliation Agreements by October 1 During the COVID-19 PHE

Events

- COVID-19: Lessons from the Front Lines Calls — May 22 and 29
- COVID-19: Home Health and Hospice Call — May 26
- COVID-19: Office Hours Call — May 26
- COVID-19: Nursing Home Call — May 27
- COVID-19: Dialysis Organization Call — May 27
- COVID-19: Nurses Call — May 28
- Prior Authorization Process and Requirements for Certain Outpatient Hospital Department Services Special Open Door Forum — May 28

MLN Matters® Articles

- COVID-19 Blanket Swing Bed Waiver for Addressing Barriers to Nursing Home Placement for Hospitalized Individuals
- Manual Update to Pub. 100-04, Chapter 38, to Remove Identification of Items or Services Related to the 2010 Oil Spill in the Gulf of Mexico Section
- National Coverage Determination (NCD) 20.19 Ambulatory Blood Pressure Monitoring (ABPM)
- National Coverage Determination (NCD 30.3.3): Acupuncture for Chronic Low Back Pain (cLBP)
- New Physician Specialty Code for Micrographic Dermatologic Surgery (MDS) and Adult Congenital Heart Disease (ACHD) and a New Supplier Specialty Code for Home Infusion Therapy Services
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - July 2020 Update
- Therapy Codes Update

Multimedia

- Procedure Coding: Using the ICD-10-PCS Web-Based Training Course — Revised

Where do I find...

Looking for something specific and don't know where to find it? Find out how to perform routine tasks or locate information that visitors frequently visit our site to accomplish or find. Check out the "Where do I find" page.

MLN Connects® for Thursday, May 28, 2020

MLN Connects® for Thursday, May 28, 2020

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News

- COVID-19: Adjusting Operations to Manage Patient Surge
- PECOS/NPPES/EHR Identity & Access Management System: Role Renamed
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Claims, Pricers & Codes

- Medicare Diabetes Prevention Program: Valid Claims

Events

- COVID-19: Lessons from the Front Lines Call — May 29

MLN Matters® Articles

- Medicare Continues to Modernize Payment Software

Multimedia

- Acute Care Hospital Inpatient Prospective Payment System — Revised

MLN Connects - Special Edition – Friday, May 29, 2020

New COVID-19 FAQs on Medicare Fee-for-Service Billing

CMS released additional *Frequently Asked Questions (FAQs)* on our recent COVID-19-related waivers to help providers, including physicians, hospitals, and rural health clinics. Find more answers to questions on.

- Outpatient therapy
- Telehealth and appropriate coding
- Federally qualified health centers

Bookmark this document and check back for additional updates.

For More Information:

- *Coronavirus.gov*
- *CMS Current Emergencies* website

MLN Connects - Special Edition – Monday, June 1, 2020

COVID-19: Using the CR Modifier and DR Condition Code

CMS revised MLN Matters Special Edition Article SE20011 on *Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)* to clarify when you must use modifier CR (catastrophe/ disaster related) and/or condition code DR (disaster related) when submitting claims to Medicare. The update includes a chart of blanket waivers and flexibilities that require the modifier or condition code.

Find out first: Subscribe to First Coast *eNews*

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MLN Connects® for Thursday, June 4, 2020

MLN Connects® for Thursday, June 4, 2020

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News

- Trump Administration Unveils Enhanced Enforcement Actions Based on Nursing Home COVID-19 Data and Inspection Results
- Hospice Provider Preview Reports: Review Your Data by June 29

Claims, Pricers & Codes

- ICD-10-PCS Procedure Codes: FY 2021

Events

- COVID-19: Lessons from the Front Lines Call — June 5

MLN Matters® Articles

- Claim Status Category Codes and Claim Status Codes Update
- Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update
- Summary of Policies in the Calendar Year (CY) 2020 Medicare Physician Fee Schedule (MPFS) Public Health Emergency (PHE) Interim Final Rules
- Value-Based Insurance Design (VBID) Model – Implementation of the Hospice Benefit Component
- Supplier Education on Use of Upgrades for Multi-Function Ventilators — Revised
- Therapy Codes Update — Revised
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--October 2020 Update — Rescinded

Publications

- Medicare Secondary Payer — Revised

MLN Connects® for Thursday, June 11, 2020

MLN Connects® for Thursday, June 11, 2020

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News

- Nursing Home COVID-19 Data and Inspections Results Available on Nursing Home Compare
- Trump Administration Encourages Reopening of Health Care Facilities
- HHS Announces New Laboratory Data Reporting Guidance for COVID-19 Testing
- Prior Authorization Process and Requirements for Certain Hospital OPD Services: Payment for Related Services

Events

- Medicare Documentation Requirement Lookup Service Special Open Door Forum — June 25

MLN Matters® Articles

- July 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.2
- July Quarterly Update for 2020 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule
- National Coverage Determination (NCD) 160.18 Vagus Nerve Stimulation (VNS)
- Quarterly Update for the Temporary Gap Period of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - October 2020

MLN Connects® for Thursday, June 18, 2020

MLN Connects® for Thursday, June 18, 2020

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News

- Hospitals: Submit Medicare GME Affiliation Agreements by October 1 During the COVID-19 PHE

Claims, Pricers & Codes

- COVID-19 Diagnostic Laboratory Tests: Billing for Clinician Services

Events

- COVID-19: Lessons from the Front Lines Call — June 19
- Medicare Part A Cost Report: New Online Status Tracking Feature Call — July 9

MLN Matters® Articles

- New Point of Origin Code for Transfer from a Designated Disaster Alternate Care Site
- July 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment
- Quarterly Update to Home Health (HH) Grouper
- NCD (20.32) Transcatheter Aortic Valve Replacement (TAVR) — Revised
- Value-Based Insurance Design (VBID) Model – Implementation of the Hospice Benefit Component — Revised

Publications

- CLIA Program and Medicare Laboratory Services — Revised
- Medicare Preventive Services — Revised

MLN Connects - Special Edition – Friday, June 19, 2020

Medicare Coverage of COVID-19 Testing for Nursing Home Residents and Patients

Today, the Centers for Medicare & Medicaid Services (CMS) has instructed Medicare Administrative Contactors and notified Medicare Advantage plans to cover coronavirus disease 2019 (COVID-19) laboratory tests for nursing home residents and patients.

This instruction follows the Centers for Disease Control and Prevention's (CDC) recent update of COVID-19 *testing guidelines for nursing homes* that provides recommendations for testing of nursing home residents and patients with symptoms consistent with COVID-19 as well as for asymptomatic residents and patients who have been exposed to COVID like in an outbreak.

Original Medicare and Medicare Advantage plans will cover COVID-19 lab tests consistent with CDC guidance.

Medicare Advantage plans must continue not to charge cost sharing (including deductibles, copayments, and coinsurance) or apply prior authorization or other utilization management requirements for COVID-19 tests and testing-related services.

Read the Medicare Learning Network article: *https://www.cms.gov/files/document/se20011.pdf.*

Read the memo to Medicare Advantage plans: *https://cms.gov/files/document/hpms-memo-diagnostic-testing-nursing-home-residents-and-patients-coronavirus-disease-2019.pdf.*

More information about Medicare coverage of COVID-19 tests is available at: *https://www.medicare.gov/coverage/coronavirus-disease-2019-covid-19-tests.*

Medicare Learning Network®

The *Medicare Learning Network®* (*MLN*) is the home for education, information, and resources for the health care professional community. The *MLN* provides access to CMS Program information you need, when you need it, so you can focus more on providing care to your patients. Find out what the *MLN* has to offer you and your staff at *https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive*.

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866-454-9007
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Electronic data interchange (EDI)
888-670-0940

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904-361-0696

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888-845-8614
877-660-1759 (TTY)
FAX: 904-361-0737

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FCSOSPOTHelp@FCSO.com

Addresses

Claims
Medicare Part B Claims
P.O. Box 2525
Jacksonville, FL 32231-0019

Redeterminations
Medicare Part B Redetermination
P.O. Box 2360
Jacksonville, FL 32231-0018

Redetermination of overpayments
Overpayment Redetermination, Review Request
P.O Box 45248
Jacksonville, FL 32232-5248

Reconsiderations
C2C Innovative Solutions, Inc.
Part B QIC South Operations
ATTN: Administration Manager
PO Box 45300
Jacksonville, FL 32232-5300

General inquiries
General inquiry request
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Jacksonville, FL 32231-0018

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Mechanicsburg, PA 17055-1849

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Provider Enrollment
2020 Technology Parkway Suite 100
Mechanicsburg, PA 17055-1849

Medical policy
Medical Policy and Procedure
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Jacksonville, FL 32231-0048
medical.policy@fcso.com

Medicare secondary payer
Medicare Part B Secondary Payer Dept.
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Overnight mail and/or special courier service
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532 Riverside Avenue
Jacksonville, FL 32202-4914

Websites

Provider
First Coast Service Options Inc. (First Coast), your CMS-contracted Medicare administrative contractor

Find your *other contractors* (e.g. DME, HHA, etc)

Centers for Medicare & Medicaid Services

E-learning Center
First Coast University

Beneficiaries
Centers for Medicare & Medicaid Services
medicare.gov

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Part B QIC South Operations
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medical.policy@fcso.com

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P.O. Box 44078
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Medicare EDI, 4C
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Medicare Part B Redetermination
P.O. Box 45056
Jacksonville, FL 32232-5056

Redetermination of overpayments
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Jacksonville, FL 32232-5015

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Part B QIC South Operations
ATTN: Administration Manager
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Jacksonville, FL 32232-5300

General inquiries
First Coast Service Options Inc.
P.O. Box 45036
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Medicare Part B Secondary Payer Dept.
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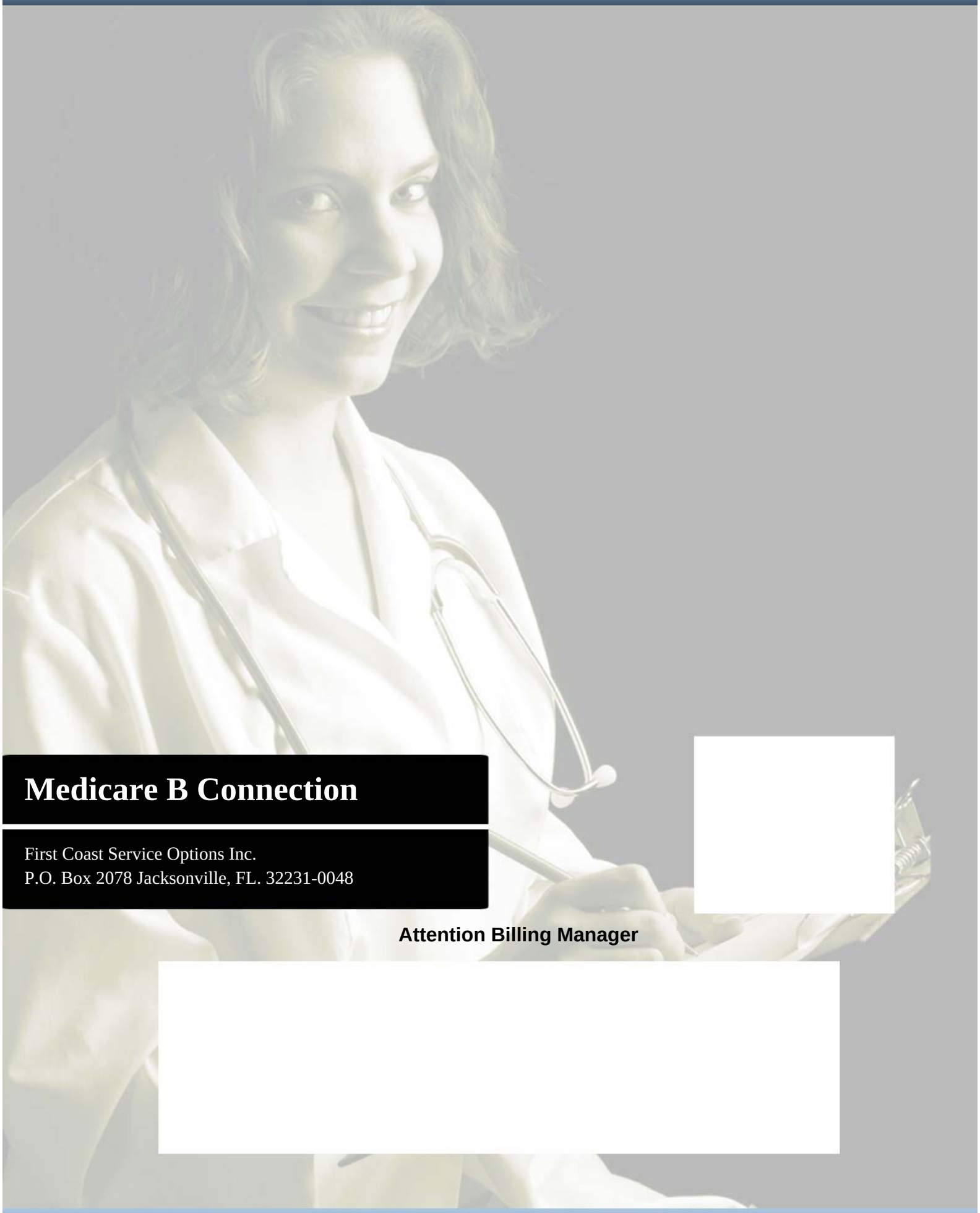

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